Washington State Department of Labor & Industries

Therapy Stakeholders Group Meeting
May 28, 2015 Tukwila Service Location, 12:30 p.m. – 3:30 p.m.

Present:

Therapy Members: Josh Cobbley – Northwest Return to Work, Jackie Earl – Cascade Summit, Cheryl French Nevin – Olympic Sports and Spine Rehabilitation, Barbara Harrington – Peoples Injury Network Northwest, Jim Strandy – Summit Rehabilitation, Lynda White – MVP Physical Therapy

LNI: Sarah Martin – Project Manager/Chair, Lauren Royer – Project Administrative Support, Rich Wilson - Project Director, Jim Kammerer – Project Lead

Updates:

- Claims Processor (CP) Pilot –
  - L&I claim processor calls the FCE clinic with approval and to request an appointment within 21 days.
  - Successful pilot with a significant reduction in delays (12 days). This is being considered to become standard work for all claim units
  - Pre-CP pilot, it was taking an *average of 28 days* from an FCE authorization to the actual test. Goal: *average of 21 days*. Non-pilot: *average of 25 days*
  - *Pilot results: average of 16 days*
- FCE Clinic Provider List – We plan to add this list to our Vendor Services Lookup Tool on our website in June.
- eCorrespondence – Summit and NW Work Options are signed up. Summit rehab indicated no issues.
  - Therapists currently do not have the access to send emails to a claims manager (secure message). This option may be added in the future in the claim & account center.
- Payment for 2nd set of PT/OT (visits 13-24) – Starting in June, L&I is aligning prior authorization with payment.
- Preferred Worker Expansion- Legislative Bill 1496 was signed by the governor. The change provides greater incentives for employers to hire injured workers.

FCE Forms Pilot – Discussed the new forms and processes

Discussion:

- Protected and unprotected versions were provided of the Capacity Summary.
- Let members know to not use spans of time, ie. 15-20 minutes. We use the lower number when something is spanned.
- JAs: We will be creating expectations that they have at least one JA (JOI) prior to the evaluation.
- Ok to add your clinic logo to the report format.
- Members noted that they get asked to review JAs posttest 40-50% of the time. In order to capture this data, we will add this data field into the pilot reporting document.

- JA's can be found in CAC if they exist. If there is a vocational provider involved, we would prefer them to send these to you as they would know which specific JA(s) are being targeted for the evaluation. It may be necessary to locate if there isn't a vocational provider or in urgent situations.
- Communicating pilot claims – they can call or fax the information to Sarah. I will send them a fax form they can use.

Process Changes:

- Document your conclusions on the Report Summary and no longer fill out the JA summary sheet or sign the JA signature page. This eliminates duplication, the potential for errors, and places the role of filling out the JA summary/signature page with the attending healthcare provider.
- No longer categorize an individual into a physical demand level. It's common for an individual to cross into different levels which can create confusion. It also doesn't take into account other elements of a job. We would like the emphasis to be on the individual factors of the worker and job instead of solely looking at a category.
- Not fill out the Capacity Summary form and portions of the Report Summary (JA response/referral questions) if the evaluator determines low effort results. If the individual did not provide adequate effort, we do not want return to work decisions made with those results. We recognize that this group has not yet developed a definition of low effort. This is still a pending issue.
    - If the worker meets a job even with low effort, note that in the Report Summary Comments section.
    - Discussion around when to stop a test due to low effort. This will be added to our issues list. If the test is stopped early, will that prevent a recommendation for full time capacity and would it impact a therapy clinic reimbursement rate.
- No longer ask the attending healthcare provider for concurrence. It is often not clear what the AP is concurring with and it isn't something necessary to adjudicate a claim. Rather it is the role of the vocational provider to seek return to work decisions by the AP.
    - Concurrence versus acknowledgement by the AP. Some clinics use their report to recommend additional services. A member noted that they do not want this option eliminated. This is why we are testing this.

Decisions

- Match the terminology of the two forms. A mismatch was found and will be corrected.
- "Never" section for lift/carry/push/pull needs to be added per the consensus of members. There are occasions never is the recommendation.
- No boxes under Reach – Waist to Shoulder category – this will be added.
- Unrestricted: Decision made to add the APF language. If the section is left blank, it means that it is unrestricted.
- Add pull down menu for minutes/hours to avoid fractions or decimals.

- Take off the report template watermark.
- Add Right, Left, Bilateral options in most of the capacities categories.
- Fingering would fall under "Fine manipulation" category.
- Floor level lifting: If the lift is actually floor level versus 6-8" off ground, member recommendation is to test for what matches the JA.
- Only use one capacity form even if unrelated conditions. The Capacity Summary form indicates whole body function. On the Capacity Summary form, mark the yes box if there were limitations due to unrelated factors. The Report Summary is the location where you separate out the related and unrelated factors.
- Projected work tolerance: If there are no restrictions, use the JOI work pattern.
- Group decided an extra coversheet was not needed to let APs/VRCs know they are part of the pilot as long as the word Pilot is on the form.
- For those cases you are asked to review a JA after the evaluation, ask the VRC if they can do the cross match based on your Capacity Summary. If they insist on filling out the JA signature page, then go ahead for now during the transition. We hope to phase this out or have a different method.

Evaluation Components

- Handed out the document we created at the last meeting.
- Members were asked whether tests used for PGAP would be appropriate for FCE evaluations. Consensus of group was not to make it part of every test but to add when psychosocial risk factors arose during the evaluation. In addition, the tests would be the standard versions to include: Roland, McGill, Tampa, Fear Avoidance.
- Due to time limitations, members were asked to review the document and make additions/changes and send back to me. The document will be sent electronically.

Full-Time Capacity Methods

- Full Time Capacity:
    - Type of test is dependent on the patient and their condition (may not have the ability to tolerate some of these tests)
    - Members noted that you would want to use multiple methods to comes up with capacity results.
    - Types of Testing - Brainstorm
        - Self-report
        - Software programs (Quest Medical, Work Well)
        - Clinical judgment
        - Bruce Test (Modified)
        - Heart Rate/Heart Rate Recovery
        - Step Test

        - Bike Test
        - Treadmill/Walking Test
        - Demonstrated positional time
        - Pre-and post-functional comparison testing to observe difference in effort (results within specific tolerances)
        - Heart rate reserve method
        - Physical condition of the patient at the time of testing
- Durational Capacity
    - Consider identifying a standard threshold
    - Types of Testing - Brainstorm
        - Heart rate
        - Demonstrated tolerance/Endurance circuit
            - Frequency and duration (at least ½ hour or greater)
            - Commonly 45-60 minute duration
            - Monitoring heart rate for heart rate recovery
            - The more rigorous test to support findings
            - Low effort observed? Consider starting at the maximum
        - Lifting
            - Isoinertial box lifting for occasional level
            - DOT extrapolation
            - PILE and EPIC for frequent level

Testing Levels

- Consideration for different levels of test – mini, regular, extended.
- Do we need to consider different levels in order to perform necessary testing to answer questions by your referral sources?
- Need to define what is “regular” – is this 1 or 2 days, how many hours.
- Mini: Possibly for activity or job task specific inquiry that would be more than what is accomplished in a standard therapy session.
- Extended – multiple day tests
- Members asked to provide L&I with feedback.

Next Meeting: Monday, July 27th.